Anchorage School District

SEIZURE ACTION PLAN

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL			GRADE

STUDENT PHOTO

SEIZURE TRIGGERS OR WARNING SIGNS

☐ Stress ☐ Intense emotions ☐ Boredom ☐ Lack of sleep

☐ Fever ☐ Television, videos, or flashing lights ☐ Other: _____

SEIZURE TYPE	LENGTH	FREQUENCY	DESCRIPTION
☐ Absence seizures (petite-mal)			A period of unconsciousness with a blank stare or what looks like daydreaming. The person may lose muscle control and make repetitive movements.
☐ Tonic-clonic or convulsive seizures (grand-mal)			The student will lose consciousness from the start of the seizure. The muscles will stiffen (tonic phase), causing him/her to fall to the floor. The extremities will then jerk and twitch rhythmically (clonic phase). Student may froth at the mouth. Breathing may be irregular. The person will regain consciousness slowly.
☐ Myoclonic seizures			Consciousness and memory are not impaired. Muscle jerks may occur in parts or all of the body.
☐			

STUDENT'S RESPONSE AFTER A SEIZURE: _____

MEDICAL PROVIDER AUTHORIZATION

BASIC SEIZURE FIRST AID		SEIZURE EMERGENCY PROTOCOL
• Stay calm and track time • Keep the student safe • Do not restrain the student • Do not put anything in the student's mouth • Stay with the student until they are fully conscious • Document the seizure occurrence	**For a tonic-clonic or convulsive seizure** • Protect the student's head • Keep airway open • Watch breathing • Turn child on their side	If student has a tonic-clonic or convulsive seizure lasting longer than 5 minutes, repeated seizures without regaining consciousness, is injured, has diabetes, has breathing difficulties, or the seizure occurs in the water… • CALL 911 and ADMINISTER EMERGENCY MEDICATION AS PRESCRIBED.

MEDICATION	USE	DOSE	ROUTE
☐ Diazepam (Diastat)	For seizures lasting _____ minutes or longer.		Rectal
☐ Midazolam	For seizures lasting _____ minutes or longer.		☐ Buccal ☐ Intranasal
☐			

☐ **YES** ☐ **NO** **Does this student have a vagal nerve stimulator (VNS)?**
Please describe use: _____

☐ **YES** ☐ **NO** **Is this student allowed to participate in usual school activities including physical education?**

☐ **YES** ☐ **NO** **Does this student require any special considerations or safety precautions?**
Please explain: _____

MEDICAL PROVIDER WITH PRESCRIPTIVE AUTHORITY IN ALASKA (PRINTED)	TELEPHONE NUMBER
MEDICAL PROVIDER SIGNATURE AND CREDENTIALS	DATE

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PARENT / GUARDIAN AUTHORIZATION

I request that the medication selected and seizure protocols listed on this plan be provided to my child. I agree to defend and hold school district employees harmless from any liability for the results of the medication, or the manner in which it is administered. I agree to defend and indemnify the school district and its employees for any liability arising out of these arrangements. I will notify the school immediately if the medication is changed. I give permission for the exchange or release of health information between the medical provider listed above and the school district as part of the provision of my child's care. I understand that this medication will be destroyed at the end of the school year, per DEA federal requirements, unless I pick up the remaining medication by the last school day, as indicated on the ASD school year calendar.

PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)		DATE

EMERGENCY CONTACTS

NAME	RELATIONSHIP TO STUDENT	PHONE NUMBER

Prescription medication must be in the original pharmacy container labeled with the following information: student name, medication, dosage, route, administration time, ordering healthcare provider, pharmacy, date issued, and prescription number.

NURSE PLAN REVIEW

I have reviewed the *Seizure Action Plan* for accuracy and ensure that all required fields and signatures are completed before administering medication to a student. I approve of the agreement arranged between the physician, parent, nurse, and student for the management of the student's health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the student in the school setting.

NURSE NAME (PRINTED)	
NURSE SIGNATURE	DATE